Reed	Skelton	Towns
Richardson	Spratt	Velazquez
Roemer	Stark	Vento
Rose	Stokes	Visclosky
Roybal-Allard	Studds	Ward
Rush	Stupak	Waters
Sabo	Tanner	Watt (NC)
Sanders	Taylor (MS)	Waxman
Sawyer	Thompson	Williams
Schroeder	Thornton	Woolsey
Schumer	Thurman	Wyden
Scott	Tiahrt	Wynn
Serrano	Torres	Yates
Skaggs	Torricelli	Zimmer

NOT VOTING—12

Chapman	Reynolds	Torkildsen
Houghton	Rivers	Tucker
Linder	Sisisky	Volkmer
Mfume	Tejeda	Wise

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So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 2275

Mr. MARTINEZ. Mr. Speaker, I ask unanimous consent that my name be removed as a cosponsor from the bill, H.R. 2275.

The SPEAKER pro tempore (Mr. HEFLEY). Is there objection to the request of the gentleman from California?

There was no objection.

APPOINTMENT OF MEMBER TO BRITISH-AMERICAN INTERPARLIAMENTARY GROUP

The SPEAKER pro tempore (Mr. BUNN of Oregon). Without objection, and pursuant to the provisions of section 168(b) of Public Law 102–138, the Chair announces the Speaker's appointment of the following member to the British-American interparliamentary group on the part of the House: The gentleman from Nebraska [Mr. BEREUTER].

There was no objection.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

INTRODUCTION OF H.R. 2350, THE PATIENT CHOICE AND ACCESS ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oklahoma [Mr. COBURN] is recognize for 5 minutes.

Mr. COBURN. Mr. Speaker, as Congress begins its consideration of reforming Medicare, I want to bring to the attention of my colleagues, perhaps the most important component of the Medicare reform debate. What must we do to ensure the quality of care that Medicare patients will receive after changes are made to the program?

While all of us in Congress are deeply concerned about the solvency of the Medicare trust fund, we must be equally concerned that the changes made to this program do not adversely affect the availability of health care to the elderly. As a practicing physician, I have spoken with my patients; and as a Member of Congress, I also have heard from thousands of my constituents. Their message is a clear one. Any Medicare reform proposal must guarantee patient choice and access quality. It must not result in a decline in the quality of care Medicare patients now receive.

For the last several months, I have been working closely with the patient access to Specialty Care Coalition, a group of 115 patient, senior citizen, physician, and nonphysician organizations, dedicated to the principle that patients must be able to access the providers of their own choice. This week, I introduced H.R. 2350, the Patient Choice and Access Act, a bill to provide protection to beneficiaries enrolled in the Medicare Program. Throughout the process of crafting a Medicare reform bill, I have been urging the House leadership to include my patient protection provisions.

The cornerstone of the current Medicare law is choice of health care provider. Presently, there is a belief that the Federal Government can save money by enrolling seniors into managed care deliver systems. And I agree how such changes can produce dramatic Federal savings, I am not opposed to the concept of managed care or a gatekeeper model. Instead, I want to make sure that quality of care for seniors is preserved, should most of the elderly population be moved into managed care. In addition, I have deep concerns about how these proposed changes in Medicare may affect my rural constituents.

Today, many major changes are taking place in the way people purchase health insurance and receive medical care. The pressures to reduce health spending continues to be intense, and health plans and providers have become more aggressive in their cost containment activities. While many health plans have developed a number of effective techniques to achieve economy and maintain quality of care, others have not always achieved that balance. Since Medicare is a federally funded program, we should make sure that these tax dollars are returned to Medicare enrollees in the form of appropriate patient care.

After changes are made to Medicare, many existing and new products will be offered to the Medicare population. Our most vulnerable population will be flung into a fiercely competitive marketplace, where access to appropriated medical services may take a back seat. I believe that in this rapidly changing environment, Medicare patients must be given basic rights and effective protection against the potential that these new markets may inappropriately restrict access to medically necessary health care services.

My legislative proposal addresses these concerns, and it puts the patient first, not the doctor, not the insurance company, but the patient. My bill is designed to improve and enhance health care to our country's senior citizens. It will not add to the cost of the Medicare Program. Under my legislation, all patients will have the option to seek the out-of-network treatment they desire no matter what health care plan they select.

True freedom of choice for patients can only be achieved by making out-of-network medically necessary treatment and services available for all health care plans. Real health care security is the freedom for patients to choose their own primary and specialty care provider, and then to continue to access these same caregivers. All patients should have the option, at an additional copayment known in advance, to seek the out-of-network treatment they desire. This point-of-service feature should be built into every health care plan, and not just offered as an option at the time of enrollment.

Patinets, especially seniors, are acting with less than perfect information about their health status at the time of enrollment. In reality, patients are unable to assess their health care needs, until they actually get sick or need specialty care. Consequently, the broadest possible patient protection is to build choice of health care provider into every health care plan.

The most effective check against abuses in this changing marketplace is the patient's power to go outside the network established by the health plan and obtain medical services. Health plans that provide good service to their enrollees will not be troubled by this requirement. Only health plans that fail to meet the needs of their subscribers will be affected.

Making out-of-network treatment and services available for enrollees in all health care plans provides a very good quality assurance check. It ensures that all health care plans provide seniors with the health care they need and deserve. If a Medicare enrollee is not satisfied with care, he or she could pursue other treatment for a reasonable, but not cost-prohibitive price.

Today, the fastest growing health insurance product is a managed care plan with the availability of out-of-network coverage. Patients have been demanding this freedom to choose, and the marketplace has responded. Requiring this type of plan for any senior is not intrusive, but rather advances a developing trend.

Building a point-of-service feature into all health plans under Medicare will not affect any health plan's ability to be aggressive in their cost-containment activities, nor will it limit their efforts to encourage providers and patients to use health care resources wisely. It will simply put pressure on health plans to keep the patient's welfare uppermost on their agenda, ahead of dividends and the bottom line.